WESTERN KENTUCKY UNIVERSITY
DENTAL HYGIENE CLINIC
1906 COLLEGE HEIGHTS #11032
BOWLING GREEN, KY 42101
(270) 745-2426

MEDICAL ALERT

PLEASE PRINT ALL INFORMATION

NAME (Last)_____ (First) _____(Middle Initial)_____

TITLE ☐Mr. ☐Mrs. ☐Miss ☐Ms. ☐Dr. HOME PHONE (_____)_____WORK/CELL PHONE (_____)_____

DATE OF BIRTH_____ ☐MALE ☐ FEMALE E-MAIL _____

MARITAL STATUS: ☐ SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED HEIGHT_____ WEIGHT_____

MAILING ADDRESS_____

CITY_____STATE_____ZIP_____ OCCUPATION_____

AFFILIATED WITH WKU? ☐YES (IF YES, HOW?) ☐STUDENT ☐FACULTY/ FAMILY ☐STAFF/FAMILY ☐OTHER _____
☐NO

HAVE YOU EVER BEEN A PATIENT IN THE WKU DENTAL HYGIENE CLINIC? ☐YES ☐NO

WHOM MAY WE THANK FOR REFERRING YOU TO OUR CLINIC? _____

RACE/ ETHNIC ORIGIN

☐AMERICAN INDIAN (ALASKAN NATIVE) ☐ASIAN PACIFIC ISLANDER ☐BLACK (AFRICAN-AMERICAN)
☐HISPANIC/LATINO ☐WHITE, NON-HISPANIC ☐OTHER_____

EMERGENCY CONTACT PERSON_____ PHONE (_____) _____
RELATION_____

PHYSICIAN'S NAME_____PHONE (_____)_____

ADDRESS _____CITY_____STATE_____ZIP_____

DENTIST'S NAME_____PHONE (_____)_____

ADDRESS _____CITY_____STATE_____ZIP_____

Payment for Services: The dental hygiene clinic has no provision for billing patients. ***Payment must be made prior to the appointment.*** We cannot accept Credit/Debit Cards. If paying by check, patient must bring proper identification at the time of appointment.

Treatment Rendered: "I understand that the WKU Dental Hygiene Clinic's primary mission is the education of dental hygiene students and therefore it does not replace regular dental examination, diagnosis, and treatment by a private dental care provider. I understand that the educational learning environment progresses slower than private practice dental care and that my total care may involve more than one appointment and/or longer appointment times. I also understand that my treatment plan is developed following an accepted standard of care. Since deviation from the treatment plan may compromise the education of dental hygiene students, I will make every effort to comply with all aspects of the treatment plan. If I am unwilling to consent to the standard of care, I may be dismissed as a patient."

Signature _____ Date_____

Signature of **Parent /Guardian**_____ Date_____

ANYONE UNDER THE AGE OF 18 MUST BE ACCOMPANIED BY PARENT/LEGAL GUARDIAN

Patient Name _____ **Date** _____

MEDICAL HISTORY	Yes	No	Comments (For Clinic Use Only)
1. Has there been any change in your general health within the past year?	☐	☐	
2. Have you been under the care of a medical doctor during the past two years? If yes, please explain:	☐	☐	
3. Have you had any serious illness or operation or been hospitalized in the past few years? If yes, describe the problem and any complications.	☐	☐	
4. Are you having pain or discomfort at this time? If yes, please explain:	☐	☐	
5. Are you now taking (or supposed to be taking) any medicine, drugs or pills of any kind (prescription and/or over the counter)? If yes, please list**:**	☐	☐	
6. Please check any of the following to which you are allergic to or to which you have reacted adversely:			
☐ Aspirin/aspirin-like products ☐ Local anesthetics ☐ Barbiturates ☐ Metals ☐ Codeine or other narcotics ☐ Penicillin or other antibiotics ☐ Iodine ☐ Sedatives/sleeping pills ☐ Latex ☐ Other_____			
7. Do you have any other allergies or have you been told not to take certain drugs, medicines or foods? If yes, please list:	☐	☐	
8. Have you ever had an adverse reaction to dental or general anesthetic?	☐	☐	
9. Do you have any medical condition(s) which require antibiotics prior to dental care?	☐	☐	
If you answered yes above**, have you taken this medication today?**	☐	☐	
10. Have you had abnormal bleeding associated with previous dental treatment?	☐	☐	
11. Are you wearing contact lenses?	☐	☐	
12. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired?	☐	☐	
13. Do your ankles swell during the day?	☐	☐	
14. Do you use more than two pillows to prop yourself up in order to sleep?	☐	☐	
15. Have you unintentionally lost or gained more than 10 pounds in the past year?	☐	☐	
16. Do you ever wake up from sleep and feel short of breath?	☐	☐	
17. Are you on a special diet?	☐	☐	
18. Do you smoke, chew, use snuff, or use any other form of tobacco?	☐	☐	
19. Do you habitually consume alcoholic beverages?	☐	☐	
20. Do you habitually use controlled substances?	☐	☐	
21. Are you currently or have you in the past participated in a substance abuse program?	☐	☐	
FOR WOMEN ONLY:	**Yes**	**No**	
Are you pregnant OR **possibly pregnant?** If yes, what month? ____ Due Date?	☐	☐	
Are you nursing?	☐	☐	
Are you undergoing hormonal contraceptive treatment? (birth control pills, implants, shots)	☐	☐	
Are you undergoing hormonal therapy?	☐	☐	

Patient Name _____ **Date** _____

Please check the box for any condition that you have had or have at present.

ORTHOPEDIC		GASTROINTESTINAL		GENITOURINARY		Comments (For Clinic Use Only)
Artificial (Prosthetic) Joint	☐	Stomach/Intestinal Ulcers	☐	Urinate Frequently	☐	
CARDIOVASCULAR		Colitis	☐	Kidney, Bladder Problems	☐	
Heart Transplant	☐	Persistent Diarrhea	☐	Dialysis	☐	
Congenital Heart Lesion/Defect	☐	Hepatitis A (Infectious)	☐	Kidney Transplant	☐	
Artificial (Prosthetic) Heart Valve	☐	Hepatitis B (Serum)	☐	Sexually Transmitted Diseases (STD/VD)	☐	
Prosthetic Implant	☐	Hepatitis C	☐	Syphilis	☐	
Indwelling Vein Catheter (Port)	☐	Liver Disease	☐	Gonorrhea	☐	
Infective endocarditis	☐	Yellow Jaundice (Other Than at Birth)	☐	Chlamydia	☐	
Heart Surgery	☐	Cirrhosis	☐	Genital Herpes	☐	
Coronary Bypass	☐	Eating Disorder	☐	HIV Positive	☐	
Angioplasty	☐	Gastric Reflux	☐	Multiple Sexual Partners	☐	
Congestive Heart Failure	☐	Hiatal Hernia	☐	**OTHER CONDITIONS**		
Heart Disease/Attack	☐	**PULMONARY**		Anxiety	☐	
Angina/Frequent Chest Pain	☐	Hay Fever	☐	Nervousness	☐	
High Blood Pressure	☐	Sinus Trouble	☐	Mental/Emotional Conditions	☐	
Heart Pacemaker or Defibrillator	☐	Allergies or Hives	☐	Unexplained Weight Loss	☐	
Aneurysm	☐	Asthma	☐	Frequent Sore Throats	☐	
HEMATOLOGIC		Chronic Cough	☐	Enlarged Lymph Nodes or Glands	☐	
Blood Transfusion	☐	Emphysema	☐	Tumor or Cancer	☐	
Anemia	☐	Chronic Bronchitis	☐	Radiation Therapy	☐	
Hemophilia	☐	Tuberculosis (TB)	☐	Chemotherapy	☐	
Leukemia	☐	Breathing Difficulties	☐			
Sickle Cell Disease	☐	**DERMAL/MUSCULOSKELETAL**				
Bleeding Disorder	☐	Allergy to Latex (Rubber)	☐			
NEUROLOGIC		Skin Rash/Hives	☐			
Physical Impairments	☐	Herpes Simplex (Fever Blisters or Cold Sores)	☐	**Disease/problem not listed If yes, please list below**	☐	
Vision	☐	Dark Mole (s) (Recent Change in Appearance)	☐			
Hearing	☐	Night Sweats	☐			
Speech	☐	Osteoarthritis (Arthritis)	☐			
Glaucoma	☐	Rheumatoid Arthritis	☐			
Earaches	☐	Pain in Jaw Joints	☐			
Ringing in the Ears	☐	Systemic Lupus	☐			
Severe Headaches	☐	**ENDROCRINE**	☐			
Fainting or Dizzy Spells	☐	Diabetes	☐			
Stroke (CVA)	☐	Thyroid Disease	☐			
Epilepsy, Seizures, or Convulsions	☐					
Psychiatric Treatment	☐					
Panic Attacks	☐					
Phobias	☐					

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. If I ever have any changes in my health or change in my medications, I will inform the student hygienist at my next appointment.

Patient Signature _____ Date _____

Patient Name _____ ***Date*** _____

DENTAL HISTORY

TREATMENT DATES	
When was the date of your last dental visit?	Date_____/_____/_____
When was the date you last received dental hygiene treatment (teeth cleaned)?	Date_____/_____/_____
What was the date of your last dental radiographs was (x-rays)?	Date_____/_____/_____

DENTAL HISTORY	**Yes or No**
Do you have regular dental exams?	☐ ☐
Are you currently having dental pain?	☐ ☐
Have you ever had any serious trouble associated with previous dental treatment? If yes, please explain:	☐ ☐
Have you ever had any adverse effects associated with a dental injection? If yes, please explain:	☐ ☐
Do dental treatments cause you much concern or worry or make you tense? If yes, please check to what extent: ☐ **slightly** ☐ **moderately** ☐ **extremely**	☐ ☐
Have you ever been diagnosed with oral cancer?	☐ ☐
Do you think your breath is offensive?	☐ ☐
Do you think your oral health is having a harmful effect on your general health at this time?	☐ ☐
Have you been instructed on the relationship between nutrition and oral health?	☐ ☐
Do you think your current nutritional habits are adversely affecting your oral health?	☐ ☐

What is the source of your drinking water? ☐city ☐well ☐cistern ☐ other_____

PLEASE CHECK IF YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:

- ☐ Oral appliances (Retainers)
- ☐ Orthodontic treatment (Braces)
- ☐ Periodontal treatment (Gum surgery)
- ☐ Endodontic therapy (Root canals)
- ☐ Removable full or partial denture (False teeth)
- ☐ Oral surgery (Removal of teeth, jaw surgery)
- ☐ Dental implants
- ☐ Sealants
- ☐ Occlusal (Bite) adjustment
- ☐ Gums bleed when you brush or floss your teeth
- ☐ Oral soft tissues (gums) frequently sore or tender
- ☐ Unpleasant taste/bad breath
- ☐ Discolored teeth
- ☐ Dry mouth
- ☐ Burning tongue/lips
- ☐ Frequent lip/mouth blisters
- ☐ Swelling/lumps in mouth
- ☐ Sore spots/irritation in mouth
- ☐ Biting cheeks/lips
- ☐ Clicking/popping jaws
- ☐ Difficulty opening/closing jaws
- ☐ Frequent sensitivity to hot/cold/sweets
- ☐ Sensitivity to biting
- ☐ Frequently have food wedge between teeth
- ☐ Clenching/grinding of teeth
- ☐ Change in bite
- ☐ Mouth breathing
- ☐ Tongue thrust

ORAL HYGIENE	**Yes or No**
Have you ever received oral hygiene instructions?	☐ ☐
Have you ever used disclosing tablets?	☐ ☐

What brand of toothpaste do you use?

PLEASE CHECK ANY OF THE FOLLOWING WHICH YOU USE TO CARE FOR YOUR TEETH AND GUMS.

- ☐ Soft toothbrush
- ☐ Hard toothbrush
- ☐ Medium toothbrush
- ☐ Powered toothbrush

Frequency of brushing? _____

- ☐ Floss
- ☐ Floss holder
- ☐ Floss threader
- ☐ Interdental brush
- ☐ Oral Irrigator
- ☐ Fluoride rinse/gel
- ☐ Prescription mouthwash
- ☐ Over-the-counter mouthwash
- ☐ Other_____

Comments
(Clinic Use Only)